# APPLICATION FOR LICENSURE AS AN ACUPUNCTURIST / PROFESSIONAL ACUPUNCTURIST

State Form 50694 (11-01)
Approved by State Board of Accounts, 2001

**HEALTH PROFESSIONS BUREAU**
402 West Washington Street, Room 041
Indianapolis, IN 46204
Telephone: (317) 234-2060
Email: hpb3@hpb.state.in.us

* Your Social Security number is being requested by this state agency in accordance with I.C. 4-1-8-1. Disclosure is mandatory, and this record cannot be processed without it.

| FOR OFFICE USE ONLY | |
|---|---|
| **APPLICATION FEE:** | |
| **DATE FEE PAID:** | |
| **RECEIPT NUMBER:** | |
| **LICENSE NUMBER:** | |
| **DATE LICENSE ISSUED:** | |

**APPLICANT**

Attach two (2) passport type quality photographs of yourself taken within the last eight weeks.

**DO NOT WRITE ABOVE THIS LINE**

## APPLICANT INFORMATION

| Name (*last, first, middle, maiden*) | Social Security number * |
|---|---|
| Current address (*number, street or Rural Route*) | |
| City, state, ZIP code | |
| Permanent address (*IF DIFFERENT FROM ADDRESS ABOVE*) | |
| City, state, ZIP code | |
| Telephone number (*daytime*) | E-mail address |
| Date of birth (month, day, year) | Birthplace |

## BASIS FOR LICENSURE

☐ Acupuncturist (*holding no other professional license*)
☐ Current Diploma of NCCAOM ☐ Other _____

| | | |
|---|---|---|
| ☐ Licensed Chiropractor | IN license number | Expiration date |
| ☐ Licensed Dentist | IN license number | Expiration date |
| ☐ Licensed Podiatrist | IN license number | Expiration date |

## ACUPUNCTURE DEGREE GRANTED BY

| Name of school | |
|---|---|
| Location | Date of graduation (*month, year*) |
| Is this program approved by the National Accreditation Commission for Schools and Colleges of Acupuncture and Oriental Medicine? | ☐ Yes ☐ No |
| If No, please explain: | |

| CHIROPRACTIC / DENTAL / PODIATRIC DEGREE GRANTED BY | |
|---|---|
| Name of school | |
| Location | Date of graduation (*month, year*) |

Have you completed 200 hours of acupuncture training in an approved college / university?

☐ Yes If Yes, please list in box below.

☐ No If No, please explain: _____

**ACUPUNCTURE TRAINING FOR DENTISTS, CHIROPRACTORS AND PODIATRISTS**
**(***Please list a minimum of 200 hours of Acupuncture Training***)**

| NAME OF PROGRAM | LOCATION | TITLE | # OF HOURS |
|---|---|---|---|
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**OTHER EDUCATION AND TRAINING IN THE UNITED STATES**

| NAME OF SCHOOL | LOCATION | FROM (*month, year*) | TO (*month, year*) |
|---|---|---|---|
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**LIST ALL PLACES YOU HAVE LIVED SINCE GRADUATION FROM ACUPUNCTURE, CHIROPRACTIC, DENTAL OR PODIATRY SCHOOL**

| GENERAL LOCATION | DATE |
|---|---|
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**LIST ALL PLACES YOU HAVE WORKED SINCE GRADUATION FROM ACUPUNCTURE, CHIROPRACTIC, DENTAL OR PODIATRY SCHOOL**

| NAME AND ADDRESS OF EMPLOYER | RESPONSIBILITIES | DATE |
|---|---|---|
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| LIST ALL STATES, INCLUDING INDIANA, IN WHICH YOU HAVE BEEN LICENSED TO PRACTICE ANY REGULATED HEALTH OCCUPATION | | | | |
|---|---|---|---|---|
| **STATE** | **TYPE OF LICENSE, CERTIFICATE, REGISTRATION OR PERMIT** | **NUMBER** | **DATE ISSUED** | **CURRENT STATUS** |
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**If your answer is "Yes" to any of the following, explain fully in a signed and notarized statement, including all related details. Include the violation, location, date and disposition. If it is a malpractice settlement or judgement against you, please provide name(s) of plaintiffs and settlement amount. Letters from attorneys or insurance companies are not accepted in lieu of your statement. Falsification of any of the following is grounds for permanent revocation of a license or permit issued pursuant to this application.**

1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold or have held in any state? ☐ Yes ☐ No
2. Have you ever been denied a license, certificate, registration or permit to practice medicine, osteopathic medicine or any regulated health occupation in any state *(including Indiana)* or country? ☐ Yes ☐ No
3. Are you now being, or have you ever been treated for a drug abuse or alcohol problem? ☐ Yes ☐ No
4. Have you ever been charged with drug addiction? ☐ Yes ☐ No
5. Have you ever been convicted of, pled guilty or *nolo contendre* to:
   A. A violation of any Federal, State or local law relating to the use, manufacturing, distribution or dispensing of controlled substances or drug addiction? ☐ Yes ☐ No
   B. Any offense, misdemeanor or felony in any state? *(Except for minor violations of traffic laws resulting in fines)* ☐ Yes ☐ No
6. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations? ☐ Yes ☐ No
7. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant? ☐ Yes ☐ No
8. Have you ever had a malpractice judgement against you or settled any malpractice action? ☐ Yes ☐ No

**APPLICATION AFFIRMATION**

I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct.

| Signature of applicant | Date signed (*month, day, year*) |
|---|---|
| | |

## AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, corporation, association, organization or institution to release to the Health Professions Bureau of Indiana any files, documents, records or other information pertaining to the undersigned requested by the Bureau or any of their authorized representatives in connection with processing my application for acupuncture licensure.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Health Professions Bureau of Indiana to disclose to the aforementioned organizations, persons, and institutions any information which is material to my application, and I hereby specifically release the Bureau, and the Board from any and all liability in connection with such disclosures.

A photostatic copy of this authorization has the same force and effect as the original.

## AFFIRMATION

I hereby swear or affirm, that I have read the above statements and agree to same.

| Signature of applicant | Date signed (*month, day, year*) |
|---|---|
| | |